104TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPT. 104–837
Part 1

UNIFORMED SERVICES MEDICARE SUBVENTION DEMONSTRATION PROJECT ACT

R E P O R T

OF THE

COMMITTEE ON NATIONAL SECURITY
HOUSE OF REPRESENTATIVES

ON

H.R. 3142

[Including cost estimate of the Congressional Budget Office]

SEPTEMBER 25, 1996.—Ordered to be printed

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Part 1

UNIFORMED SERVICES MEDICARE SUBVENTION DEMONSTRATION PROJECT ACT

SEPTEMBER 25, 1996.—Ordered to be printed

Mr. SPENCE, from the Committee on National Security, submitted the following

REPORT

[To accompany H.R. 3142]

[Including cost estimate of the Congressional Budget Office]

The Committee on National Security, to whom was referred the bill (H.R. 3142) to establish a demonstration project to provide that the Department of Defense may receive Medicare reimbursement for health care services provided to certain Medicare-eligible covered military beneficiaries, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Uniformed Services Medicare Subvention Demonstration Project Act".

SEC. 2. DEFINITIONS.

For purposes of this Act:

(1) MEDICARE-ELIGIBLE COVERED MILITARY BENEFICIARY.—The term "medicare-eligible covered military beneficiary" means a beneficiary under chapter 55 of title 10, United States Code, who—

(A) is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.); and

(B) is enrolled in the supplementary medical insurance program under part B of such title (42 U.S.C. 1395j et seq.).

(2) TRICARE PROGRAM.—The term "TRICARE program" means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United States Code, principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.

(3) MILITARY TREATMENT FACILITY.—The term "military treatment facility" means a facility of the uniformed services used for the provision of medical or dental care.

(4) SECRETARIES.—The term "Secretaries" means the Secretary of Defense and the Secretary of Health and Human Services acting jointly.

SEC. 3. ESTABLISHMENT OF DEMONSTRATION PROJECT.

(a) ESTABLISHMENT REQUIRED.—The Secretary of Defense and the Secretary of Health and Human Services shall jointly establish a demonstration project to provide the Department of Defense with reimbursement, in accordance with section 4, from the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care services provided to medicare-eligible covered military beneficiaries who participate in the demonstration project and receive the health care services through the managed care option of the TRICARE program.

(b) GEOGRAPHIC REGIONS.—The Secretaries shall conduct the demonstration project in two or more geographic regions in which the TRICARE program has been implemented.

(c) DURATION.—The Secretaries shall conduct the demonstration project during the three-year period beginning on January 1, 1997.

(d) EXPANSION OF DEMONSTRATION PROJECT.—The Secretaries shall include in the demonstration project a provision for expanding the demonstration project to incorporate health care services provided to medicare-eligible covered military beneficiaries under the fee-for-service options of the TRICARE program if, in the report required by section 713 of the National Defense Authorization Act for Fiscal Year 1997, the Secretaries determine that such expansion of the demonstration project is feasible and advisable.

(e) REPORTING REQUIREMENTS.—Not later than 15 months after the establishment of the demonstration project, and then not later than 90 days after the end of the demonstration project, the Secretaries shall submit to Congress a report containing the following:

(1) The number of medicare-eligible covered military beneficiaries opting to participate in the demonstration project established under this section instead of receiving health benefits through another health insurance plan (including through the medicare program).

(2) An analysis of whether, and in what manner, easier access to the military treatment system affects the number of medicare-eligible covered military beneficiaries receiving health benefits under the medicare program.

(3) A list of the health insurance plans and programs that were the primary payers for medicare-eligible covered military beneficiaries during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

(4) An identification of cost-shifting (if any) among medical care programs as a result of the demonstration project and a description of the nature of any such cost-shifting.

(5) An analysis of how the demonstration project affects the overall accessibility of the military treatment system and the amount of space available for point-of-service care and a description of the unintended effects (if any) upon the normal treatment priority system.

(6) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project.

(7) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

(8) A description of the effects that the demonstration project, if permanent, would be expected to have on the overall budget of the military health care system and the budgets of individual military treatment facilities.

(9) An analysis of whether the demonstration project affects the cost to the Department of Defense of prescription drugs or the accessibility, availability, and cost of such drugs to program beneficiaries.

SEC. 4. REIMBURSEMENT AMOUNTS.

(a) PAYMENT TO DEPARTMENT OF DEFENSE.—The Secretary of Health and Human Services shall make monthly payments to the Department of Defense from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (allocated by the Secretary of Health and Human Services between each Trust Fund based on the relative weight that benefits from each Trust Fund contribute to the required payment) in an amount equal to 1/12 of the amount determined under subsection (b) for each medicare-eligible covered military beneficiary enrolled during the year in the managed care option of the TRICARE program in

the geographic region in which the demonstration project is conducted, but only if such beneficiary's enrollment is in excess of the minimum enrollment number determined under subsection (c)(1) for the geographic region.

(b) AMOUNT DETERMINED.—The amount determined under subsection (a) is an amount equal to 93 percent of the average adjusted per capita cost determined under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) for the year.

(c) ESTABLISHMENT OF MINIMUM AND MAXIMUM ENROLLMENT LEVELS.—

(1) MINIMUM.—Based on the best available data, the Secretaries shall establish a minimum enrollment number of medicare-eligible covered military beneficiaries who are required to enroll in the managed care option of the TRICARE program during a year in each geographic region in which the demonstration project is conducted before the Department of Defense may receive payment under subsection (a).

(2) MAXIMUM.—The Secretaries shall establish a maximum number of medicare-eligible covered military beneficiaries for which payment may be made by the Secretary of Health and Human Services under subsection (a).

(3) DETERMINATION OF BASELINE COSTS.—Before the establishment of the demonstration project, the Secretaries shall establish the minimum and maximum enrollment numbers so that—

(A) the expenditures by the Department of Defense for such number of medicare-eligible covered military beneficiaries is equivalent to the projected expenditures that would have been made by the Department for such beneficiaries if the demonstration project had not been established; and

(B) the cost to the medicare program under the demonstration project does not exceed the cost that the medicare program would otherwise incur with respect to the medicare-eligible covered military beneficiaries participating in the demonstration project in the absence of the project.

(d) TRICARE PROGRAM ENROLLMENT FEE WAIVER.—The Secretary of Defense shall waive the enrollment fee applicable to any medicare-eligible covered military beneficiary enrolled in the managed care option of the TRICARE program for whom reimbursement in the amount determined under subsection (b) is received under subsection (a).

(e) REVIEW BY COMPTROLLER GENERAL.—Not later than December 31 each year in which the demonstration project is conducted, the Comptroller General shall determine and submit to the Secretaries and Congress a report on the extent, if any, to which the costs of the Secretary of Defense under the TRICARE program and the costs of the Secretary of Health and Human Services under the medicare program have increased as a result of the project.

(f) DEMONSTRATION PROJECT ADJUSTMENTS FOLLOWING REVIEW.—Based on the review prepared under subsection (e), the Secretaries shall modify the demonstration project at the end of each year to correct for any discrepancy between cost targets and actual spending under the demonstration project. From funds available to the Secretary of Defense for the defense health care program, the Secretary of Defense shall reimburse the Secretary of Health and Human Services for any excess costs incurred by the medicare program in violation of subsection (c)(3)(B).

PURPOSE AND BACKGROUND

H.R. 3142 would establish a demonstration program to provide Medicare subvention or reimbursement to the Department of Defense (DOD) for health care services provided to certain Medicare-eligible military beneficiaries. The goal of the demonstration program would be to improve access to needed health care services for these military beneficiaries, while determining whether subvention can be accomplished in a manner that does not increase costs to the federal government or the Medicare Trust Fund.

Presently, there are about 1.2 million Medicare-eligible military beneficiaries. Although these beneficiaries are eligible to use military medical facilities on a space-available basis, they are not eligible to enroll in, or participate in, the DOD's TRICARE managed health care program. With bases being closed and realigned throughout the country, access to military medical facilities is becoming increasing difficult for these beneficiaries. Exacerbating the

situation is the fact that the TRICARE program is designed to maximize use of military medical facilities by TRICARE program enrollees.

The Department of Defense estimates that about 25 percent of military Medicare-eligible beneficiaries currently rely on military facilities for the majority of their health care needs. Supporting this population, which is projected to grow 29 percent by the year 2001, costs DOD about $1.4 billion a year. Continuing to meet the medical needs of this growing military beneficiary population is an extremely difficult challenge, particularly in today's budget-constrained environment.

The committee believes that Medicare reimbursement to DOD for care provided to Medicare-eligible beneficiaries can produce savings to both DOD and the Department of Health and Human Services because military hospital care is generally less expensive than health care services purchased in the private sector. Conducting a Medicare subvention demonstration program is a viable means of determining whether subvention will in fact save the federal government money, as well as whether implementing subvention on a large-scale, national level is feasible.

H.R. 3142 would establish a subvention demonstration program to be conducted in two TRICARE regions over a three-year period. Under the program, Medicare-eligible retirees who chose to participate in the demonstration would be required to enroll in the TRICARE HMO option—TRICARE Prime—and would receive all their medical care through the military health services system. As TRICARE enrollees, program participants would have a higher priority for receiving medical care in military facilities than non-enrollees and would be guaranteed access to treatment within a specific amount of time.

To ensure the demonstration is, at a minimum, cost-neutral to the Medicare Trust Fund, DOD would continue to provide the same amount of care to Medicare-eligible military beneficiaries as it now does. Once that level of effort has been met, Medicare would begin to reimburse DOD for additional care provided to Medicare-eligible beneficiaries, at a rate lower than that at which it reimburses civilian Medicare providers and health maintenance organizations. H.R. 3142, as amended by the committee, also would provide for an annual General Accounting Office review of the program to determine whether there have been any cost overruns.

To ensure that the demonstration is valid and yields sufficient data for determining the viability of full-scale implementation of subvention, the committee intends that the demonstration be conducted throughout the two TRICARE demonstration regions—not just at a few specific sites within the two regions as has been proposed by the Administration—and include the Department's civilian health care providers operating within the demonstration region.

LEGISLATIVE HISTORY

H.R. 3142, the "Uniformed Services Medicare Subvention Demonstration Project Act," was introduced on March 21, 1996. It was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce and National Security.

The origins of the legislation can be traced back to the National Defense Authorization Act for Fiscal Year 1993 (Public Law 102–484) which directed the Secretaries of Defense, Health and Human Services and Transportation to examine the option of Medicare reimbursement to the Department of Defense for medical care provided to military Medicare-eligible retirees.

H.R. 580, introduced on January 19, 1995, sought to amend title XVIII of the Social Security Act and title 10, United States Code, to allow the Secretary of Health and Human Services to reimburse the Military Health Services System for care provided to Medicare-eligible military retirees and their spouses in that system. The National Defense Authorization Act for Fiscal Year 1996 (section 718 of Public Law 104–106) expressed the sense of Congress that the President's budget for fiscal year 1997 should provide for reimbursement by the Health Care Financing Administration to the Department of Defense for health care provided to Medicare-covered beneficiaries. The President's budget request for fiscal year 1997 did not include Medicare reimbursement to DOD.

On March 7, 1996, the Subcommittee on Military Personnel conducted a hearing on alternatives for military retiree health care, including Medicare reimbursement to the Department of Defense. On September 11, 1996, the Subcommittee on Military Personnel held a hearing to specifically address the issue of Medicare subvention and H.R. 3142.

On September 12, 1996, the Committee on National Security met to consider H.R. 3142. The committee agreed to an amendment in the nature of a substitute. The bill, as amended, was ordered reported favorably to the House by a unanimous voice vote.

COMMITTEE POSITION

On September 12, 1996, the Committee on National Security, a quorum being present, approved H.R. 3142, as amended, by a unanimous voice vote.

FISCAL DATA

Pursuant to clause 7 of rule XIII of the Rules of the House of Representatives, the committee attempted to ascertain annual outlays resulting from the bill during fiscal year 1997 and the four following fiscal years. The results of such efforts are reflected in the cost estimate prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974, which is included in this report pursuant to clause 2(l)(3)(C) of House rule XI.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

In compliance with clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, the cost estimate prepared by the Congressional Budget Office and submitted pursuant to section 403(a) of the Congressional Budget Act of 1974 is as follows:

SEPTEMBER 17, 1996.

Hon. FLOYD SPENCE,
Chairman, Committee on National Security,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate of H.R. 3142, the Uniformed Services Medicare Subvention Demonstration Project Act, as ordered reported by the House Committee on National Security on September 12, 1996.

The bill will affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 3142.

2. Bill title: Uniformed Services Medicare Subvention Demonstration Project Act.

3. Bill status: As ordered reported by the House Committee on National Security on September 12, 1996.

4. Bill purpose: The bill would create a demonstration project to allow Medicare to reimburse the Department of Defense (DoD) for health care that Medicare beneficiaries receive in military treatment facilities through the managed care option of the TRICARE program.

5. Estimated cost to the Federal Government: The table below summarizes the budgetary effects of the bill. It shows the effects of the bill on direct spending and authorizations of appropriations.

[By fiscal years, in millions of dollars]

	1996	1997	1998	1999	2000	2001	2002
DIRECT SPENDING							
Spending Under Current Law:							
Estimated budget authority	198,191	217,200	238,144	259,683	281,215	304,913	330,923
Estimated outlays	196,051	215,516	236,419	257,411	279,466	303,179	328,522
Proposed Changes:							
Estimated budget authority	0	150	200	200	50	0	0
Estimated outlays	0	150	200	200	50	0	0
Spending Under the Bill:							
Estimated budget authority	198,191	217,350	238,344	259,883	281,265	304,913	330,923
Estimated outlays	196,051	215,666	236,619	257,611	257,516	303,179	328,522
SPENDING SUBJECT TO APPROPRIATIONS ACTION							
Spending Under Current Law:							
Estimated auth. level [1 2]	15,117	15,117	15,117	15,117	15,117	15,117	15,117
Estimated outlays	15,166	15,196	15,092	15,080	15,084	15,084	15,084
Proposed Changes:							
Estimated auth. level [3]	0	−150	−200	−200	−50	0	0
Estimated outlays	0	−100	−200	−200	−100	0	0
Spending Under the Bill:							
Estimated auth. level [1 2]	15,117	14,967	14,917	14,917	15,067	15,117	15,117
Estimated outlays	15,166	15,096	14,892	14,880	14,984	15,084	15,084

[1] The 1996 figure is the amount already appropriated.

[2] Amounts for fiscal year 1997 through 2002 are authorizations subject to appropriations action and assume that appropriations under current law remain at the 1996 level. If they are adjusted for inflation the base amounts would increase by about $450 million a year, but the proposed changes would remain as shown in the table.

[3] These estimates exclude the costs to administer and evaluate the demonstration program.

6. Basis of estimate: The bill would require that the demonstration occur in two or more geographic regions over a three-year period beginning on January 1, 1997. The estimate assumes that the project is limited to three of the Department of Defense's administrative regions—fewer than the bill would allow, but more than anticipated in a recent memorandum of agreement (MOA) between DoD and the Health Care Financing Administration (HCFA). The MOA defines a demonstration at several specific sites, but CBO assumes that under legislation that would give broader authority the MOA would be revised.

Under the bill, Medicare would reimburse DoD for expenditures above a base level of effort, which would be determined by DoD and HCFA in order that the demonstration project not raise overall Medicare costs. (The MOA contains a similar objective but would attempt to achieve it in a different way.)

Direct spending

Even though the bill aims at no change in Medicare's or DoD's costs, CBO believes Medicare costs would rise by about $200 million a year. This increase would stem from information and administrative problems in determining what each agency would have spent under current law.

The stipulation that the project be budget neutral for both DoD and Medicare would be extremely difficult to implement. Although one could argue that the measurement problems could go either way, there are at least three reasons to believe that Medicare's costs would rise under the subvention demonstration program.

First, knowing how many Medicare beneficiaries will seek care directly from DoD is difficult enough in the short term, and that uncertainty only grows over time as populations change and the availability of discretionary funding for DoD's health care programs varies. DoD does not have complete information about the extent to which its beneficiaries currently receive additional care from other sources, such as Medicare. Thus, establishing a baseline level is subject to considerable uncertainty about the numbers of beneficiaries, the extent of their receipt of care from non-DoD sources, and their response to being included in the TRICARE enrollment system. Despite the current lack of an enrollment system, data from DoD indicate that it provides all health care to the equivalent of 68,000 or about 30 percent of the 220,000 Medicare-eligible retirees or dependents living in the three regions. Probably many more people receive at least some care from DoD, but the number averages out to being the equivalent of all care for 68,000 people. If healthy retirees are undercounted in the baseline level, they would become the financial responsibility of HCFA under the bill, even though they now get most of their care from DoD.

Second, DoD and HCFA face different incentives and access to information. As a result, DoD would have an advantage in the negotiations with HCFA over the baseline level of care that would work against budget neutrality. The demonstration would tend to attract beneficiaries who had previously used a military treatment

facility. DoD would therefore have information on potential participants' medical people to the demonstration. Moreover, DoD has a greater incentive to shift its costs to Medicare than HSCA has to prevent shifting. Because annual discretionary appropriations currently limit DoD's health care funding, the department would have to eliminate personnel or otherwise reduce its program in the face of losses from an inaccurate baseline level (alternatively, it could expand its programs if it can shift costs to Medicare). However, HCFA pays Medicare costs from a permanent and indefinite appropriation that is very large and would not readily reveal a loss stemming from a demonstration program such as this one. Even after the fact, it would not be easy for the General Accounting Office or any other auditing agency to determine the financial outcome of the demonstration because it, too, would have to rely on estimates and assumptions about events and behavior that would have otherwise occurred under current law.

Third, because Medicare's current method of paying risk plans does not adequately adjust for differences in health status among beneficiaries, Medicare's costs would rise if relatively healthy beneficiaries who would otherwise receive care in the private sector on a fee-for-service (FFS) basis choose to receive it in DoD's managed care (MC) program. (The demonstration program would pay slightly less for participants who would otherwise be enrolled in a managed care plan under Medicare.) The sector in which participants would otherwise be enrolled has important implications for the bill's potential costs: Maximum enrollment in the demonstration project would depend on an estimate of whether the participants would otherwise be enrolled in FFS or MC. If the estimate was that a large number of MC enrollees would participate, the maximum enrollment permitted under the bill would be high. If participants actually would have been FFS enrollees, however, the demonstration would incur costs for a large number of participants.

On balance, CBO estimates that DoD could shift 50 percent of its costs under the demonstration to Medicare because of measurement problems and institutional features. First, a 20 percent to 30 percent error could easily occur in measuring current efforts, and uncertainty about the future could add another 20 percent to 30 percent at least. Second, the differing incentives and access to information would lead to errors that compound rather than offset.

This estimate also assumes that the demonstration project would take place in three of DoD's administrative regions—Region 6 (Texas), Region 11 (Washington/Oregon), and Region 12 (Hawaii/Pacific). Those regions contain approximately 220,000 retired military personnel and their dependents who are entitled to Medicare insurance coverage in addition to being eligible to receive care in DoD medical facilities. The estimate assumes that 30 percent of the eligible population in those regions would ultimately enroll in DoD's managed care program to continue to receive their care from DoD. Finally, Medicare is assumed to reimburse DoD at a rate of $5,425 per capita in 1997, a rate that would rise to about $6,775 in 2000.

Spending subject to appropriations action

In terms of its relationship with DoD, HCFA would pay more to DoD than it now pays to the private sector, and DoD would be free to spend the extra reimbursement on things other than medical care for the beneficiaries eligible for Medicare.

The increase in mandatory spending would allow discretionary authorizations to decline by the same amount because DoD would be able to spend the receipts from Medicare. The same factors that would lead to higher Medicare costs would obscure whether or in what amounts this demonstration project was providing net additional resources to DoD. Whether discretionary savings would actually occur would depend on annual appropriation action.

On the other hand, discretionary costs would rise to cover HCFA's and DoD's administrative costs to manage and evaluate the demonstration project. These costs would probably amount to a few million dollars.

7. Pay-as-you-go considerations: The balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

[By fiscal years, in millions of dollars]

	1996	1997	1998
Change in outlays	0	150	200
Change in receipts	(1)	(1)	(1)

[1] Not applicable.

8. Estimated cost to State, local, and tribal governments: The bill contains no intergovernmental mandates as defined by the Unfunded Mandates Reform Act of 1995 (Public Law 104–4) and would have no significant impacts on the budgets of state, local, or tribal governments.

9. Estimated impact on the private sector: This bill would impose no new federal private-sector mandates as defined in Public Law 104–4.

10. Previous CBO estimate: None.

11. Estimate prepared by: Federal Cost Estimate: Michael A. Miller; Impact on State, Local and Tribal Governments: Pepper Santalucia; Impact on Private Sector: Neil Singer.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

COMMITTEE COST ESTIMATE

With respect to clause 7(a) of rule XIII of the Rules of the House of Representatives, the committee disagrees with the Congressional Budget Office (CBO) cost estimate of H.R. 3142, particularly as it pertains to the validity of certain assumptions underlying this estimate.

The CBO cost estimate asserts limited confidence in the ability of the Department of Defense (DOD) and the Health Care Financing Administration (HCFA) to arrive at an accurate baseline level of beneficiary enrollment because of a paucity of good enrollment data. CBO also contends that, to the extent that such data exists, DOD has better data than HCFA and would use this advantage to

negotiate an enrollment baseline and reimbursement arrangement which would shift health care costs to the Medicare program. DOD would then be free to use any savings for other purposes.

CBO has based its scoring upon these assumptions despite provisions in H.R. 3142 which specifically prohibit such cost shifting actions and which limit HCFA's potential liability for Medicare eligible beneficiaries to current law levels. CBO also dismisses, without analytical justification, HCFA's ability to act as an informed participant in the negotiations with DOD and to establish the appropriate level of reimbursement. The CBO assumes a level of concerted bureaucratic malfeasance that is unsupported by any empirical data and that runs counter to the experience of this committee.

CBO also asserts that relatively healthy retirees who currently receive care on a fee-for-service basis under Medicare would move in great numbers to a DOD managed care system. CBO claims this migration of relatively healthy, low cost, beneficiaries would result in higher direct spending because HCFA would reimburse DOD on a per-capita basis that would exceed the current per-capita cost of care for this group. CBO provides no justification for this assumption. Indeed, the ability to choose health care providers is one of the key features of Medicare that most beneficiaries want to see preserved under any reform proposal. CBO offers no compelling analysis to support the proposition that military retirees receiving care on a fee-for-service basis would behave differently than other people and migrate in large numbers to a managed care system. This specific concern is addressed in the evaluation design contained in the memorandum of agreement (MOA) between DOD and HCFA—the Administration's specific plan for implementing the demonstration required by this bill.

Furthermore, both the bill and the implementing plan would require any eligible beneficiaries who participate in the demonstration to receive all their medical care through the Department's TRICARE managed health care program. This requirement could actually produce savings to the federal government by limiting the current practice of "double dipping"—military beneficiaries who use both their Medicare benefits and the military health services system depending on which option is more convenient or less costly. This practice frequently results in the federal government paying twice for health services provided to these individuals. The requirement for demonstration participants to use only one of these two health care system would serve to prevent this prevent this practice and save the federal government money. The CBO estimate wholly failed to address such potential savings.

Finally, CBO's scoring of H.R. 3142 assumes a demonstration conducted in three TRICARE regions. While the bill does allow for the demonstration to be conducted in two or more regions, it does not require that it be conducted in more than two TRICARE regions. Additionally, the Administration's specific plan for implementing this bill—the MOA between DOD and HCFA—would require the demonstration to be limited to only two TRICARE regions. Thus, the CBO estimate likely significantly overstates the actual cost of the demonstration program.

H.R. 3142 would not affect any retiree who is not currently entitled to receive benefits under the Medicare program. The bill would

do nothing to increase or decrease the potential liability of the Medicare program. CBO's scoring of the bill reflects an unrealistic, worst case scenario. Under the current system, DOD is essentially buying down the Medicare program's liabilities by using defense discretionary funds to provide health care benefits to Medicare eligible military retirees. CBO's argument that this bill will lead to an increase in entitlement spending is therefore misleading since the legal entitlement, and attendant liability on the part of the government, already exists.

The budgetary implications of H.R. 3142 should be considered in light of the following example: when a military hospital is closed, the secondary effect of eligible military retirees who received care at that facility migrating to the Medicare program is not considered as a direct spending argument against closing the hospital. Similarly, HCFA's duty to provide health care for all Medicare eligible retirees should not be considered reduced simply because DOD has annually spent a portion of its limited discretionary funds to provide adequate health care for military retirees.

The committee believes that the bill may result in some small increases in discretionary costs to DOD associated with management of the demonstration project. However, the bill contains specific safeguards to prevent any of the increases in direct spending assumed in the CBO estimate. As a result, the committee does not agree with the principal assumptions which form the basis of the CBO cost estimate and therefore does not believe that the estimate is an accurate forecast of the actual costs to the government of this legislation.

INFLATION IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the committee concludes that the bill would have no significant inflationary impact.

OVERSIGHT FINDINGS

With respect to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, this legislation results from hearings and other oversight activities conducted by the committee pursuant to clause 2(b)(1) of rule X.

With respect to clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974, this legislation does not include any new spending or credit authority, nor does it provide for any increase or decrease in tax revenues or expenditures. The fiscal features of this legislation are addressed in the estimate prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974.

With respect to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the committee has not received a report from the Committee on Government Reform and Oversight pertaining to the subject matter of H.R. 3142.

STATEMENT OF FEDERAL MANDATES

Pursuant to section 423 of Public Law 104–4, this legislation contains no federal mandates with respect to state, local, and tribal governments, nor with respect to the private sector. Similarly, the bill would provide no unfunded federal intergovernmental mandates.

ROLLCALL VOTES

With respect to clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, no roll call votes were taken with respect to the committee's consideration of H.R. 3142.

The committee ordered H.R. 3142 reported to the House with a favorable recommendation by a unanimous voice vote, a quorum being present.

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